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CONTENTS.

PROCEEDINGS OF THE AMERICAN GYNÆCOLOGICAL SOCIETY.

(Specially reported for the MEDICAL NEWS By FRANK WOODBURY, M.D.)

The third annual meeting of the American Gynæcological Society was convened in Philadelphia, September 25, 1878, and continued in session for three days. The meetings were held both morning and afternoon, at the Hall of the College of Physicians; they were full of interest, and were largely attended by the Fellows of the Society and the profession at large. The entire active membership now amounts to only forty-three, being limited by the Constitution to sixty.

First Day.—The meeting was called to order at 10.30 A. M., by Vice-President Dr. WM. GOODELL. The Secretary, Dr. JAS. R. CHADWICK, announced the receipt of invitations to visit a number of public institutions.

Dr. ALBERT H. SMITH, of Philadelphia, then delivered a brief address of welcome.

Dr. J. C. REEVE, of Dayton, reported a *Case of Rupture of the Perineum without Implication of the Vulva* in a multipara; no cause for the recto-vaginal rupture could be assigned except a precipitate labor; the fœtus being rapidly delivered through the rectum while she was sitting on a vessel. Such cases are rare. Where such an accident occurs it is almost always in a primipara; when it is encountered in a multipara it is generally found that there are some bands of vaginal cicatricial tissue, or other abnormal condition, preventing natural delivery. The accident may generally be prevented by prompt treatment. Dr. Matthews Duncan recently reported a series of cases where this condition was averted by the use of the forceps, and Dr. Fordyce Barker a case where the arm protruded through the anus, but the child was delivered by the vagina. Laxity of the perineum has been theoretically suggested as a cause for central rupture, but if this were true it should occur most often among multipara, which is not the case. In the subject of the report there was not marked relaxation of the perineum. The wound was brought together with the quilled sutures, which were afterwards cut between the stitches to make them lie smooth.

Dr. JAS. P. WHITE, of Buffalo, believed this form of rupture could be prevented, generally, by making bi-lateral or tri-angular incisions of the perineum, whenever laceration is threatened. He reported a case, in which such incisions were made and no laceration occurred. The same patient falling in labour again, it was decided to leave it to nature, when, in spite of the greatest care, a tear occurred, not in the line of former incisions but directly back into the rectum. These incisions are simple, free from danger,

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and readily heal; they are very valuable and should be more generally practised.

Dr. REEVE, of Dayton, remarked that in cases of torn perineum, the operation should either be performed immediately after the labour, or if this cannot be done it should be delayed several months to let the wound contract as much as it will.

The paper of Dr. J. MARION SIMS, *On the Surgical Treatment of Stenosis of the Cervix Uteri*, was of considerable length. Dr. Sims being absent, abstracts from the article were read by the Secretary.

In operating the patient should be placed in Sims's position, the duck-bill speculum introduced, the uterus seized and pulled down with a tenaculum, when antero-posterior incisions are to be made with Sims's knife in the posterior and anterior lip. The dilator may now be introduced, if thought necessary, and, the uterus being restored to its place, the canal dilated to the desired extent. Pulling the uterus down again with a tenaculum a glass plug is placed in the uterine canal, a pledget of cotton wet with solution of alum placed against the cervix, and the vagina packed with cotton-wool. The patient remains in bed, and a catheter is used for a day or two. He has abandoned iron as a styptic, and uses a solution of alum (1 to 12) with carbolic acid (1 to 40). Has had two cases of hemorrhage, both due to want of proper care in the after-treatment. Serious bleeding sometimes follows the metrotome caché, but no operation is unaccompanied by danger. When the flexion is so great that the knife cannot be readily introduced a grooved director should be used. In cases of dysmenorrhœa caused by uterine flexion, especially where the posterior lip is thick and long, the Sims's operation is particularly serviceable. The passage of a medium-sized sound into the uterus does not prove that there is no necessity for the operation, for the canal may be nearly closed by the flexion so as to produce symptoms of stricture. One of his cases died of peritonitis following hemorrhage from displacement of plug in getting out of bed; another died from the bursting of an abscess in the Fallopian tube, the patient having had chronic salpingitis. Pelvic cellulitis may appear on the fifth or sixth day; to prevent this antiseptic precautions are recommended during operation. The paper establishes the following points:—

1. The bi-lateral operation is adapted to relieve those cases of mechanical dysmenorrhœa, where the lips of the cervix preserve their normal relations, and the os points directly backward.

2. The antero-lateral incisions are best in cases where the posterior lip is markedly hypertrophied, so that the cervical canal apparently corresponds with the long axis of the vagina.

3. The bi-lateral operation is Simpson's.

4. The antero-posterior operation belongs to Sims.

In opening the discussion upon the paper Dr. FORDYCE BARKER said that it is now nearly thirty-three years since Sir Jas. Y. Simpson first suggested and perfected the bi-lateral incision for the cure of dysmenorrhœa and sterility, and it is nearly twenty years since Sims introduced and perfected the antero-posterior incision for certain forms of stenosis of the cervix, and it must be acknowledged that there are yet wanting precise rules for recognizing the conditions requiring the operation. Why is it that one operator finds it necessary to perform it 383 times, another over 300 times, and the author of the paper nearly one thousand times, while others with equal opportunities for observation, and equally capable, consider it rarely necessary? The fact that the operator who had performed it the most frequently thinks that such precise rules as he has laid down are necessary, shows that it is not free from danger.

There has prevailed a mania for incision of the cervix uteri by which great injury has been done. Deaths have occurred even in such skilful hands as Dr. Sims's, but in less experienced hands many cases of death have doubtless occurred, which have never been reported. The speaker himself was cognizant of sixteen deaths from this operation in the city of New York alone, and it must be conceded that many others must have occurred elsewhere which have not been published.

The practical question is that of treatment. We are all prepared to admit that stenosis producing dysmenorrhœa should be treated, and would even justify an operation of some severity. The special one proposed is always attended with some danger, and the greater the experience of the operator the greater caution does he learn to use in performing it; but "fools rush in where angels fear to tread," and the inexperienced rashly undertake it in unsuitable cases, and harm often results. The object aimed at by the operation is to allow the menstrual fluid to pass out; and, secondly, to permit the free passage of the fecundating element; and sometimes to straighten the canal of the cervix. How is it that some have becqme enthusiastic in favour of the operation, and others of equal ability think it necessary to perform it less and less? Is it because those who become great operators are placed in a position not to judge correctly of the results of their own operations? Let us suppose a case that falls into the hands of a skilled surgeon. She is placed in the care of a trained nurse at the hospital; she receives daily visits from the physician, and is fully under his control; temporary improvement is almost sure to occur. After she leaves, if the operation prove a success, there is no danger that he will not be acquainted with the results; if it is unfavourable there are many reasons why the operator will not learn of it, as the case falls into the hands of other physicians. In the last fifteen years the speaker had seen at least 100 cases where incision of the cervix had been unsuccessfully performed for the treatment of sterility; performed both by eminent men and others not so well known to the profession.

Dr. Ellwood Wilson, of Phila., said he was not an advocate of the operation, but prefers dilatation with the forceps, from which he had never seen any bad results, and his success, as a rule, was satisfactory. The patient keeps her bed for 24 hours, and the only after treatment required is a tepid soap and water injection.

Dr. Noeggerath, of New York, remarked, that this operation is not performed as frequently as it used to be, is largely due to the efforts of the late Dr. Peaslee. He would add two objections. In a case of ante-flexion of the second degree it is readily seen that, while this incision of the cervix is made to straighten the canal, it cannot do it. Secondly, an incision carried into the parenchymatous structure of the uterus, where there are lymphatic glands and vessels, may lead to inflammation and septicæmia. The normal calibre of the internal os is one-fifth and of the outlet one-fourth of an inch, and it is never necessary to go beyond the normal size of the canal. Peaslee's operation accomplishes all that is required. In order to determine the comparative value of these expedients statistics should be prepared giving the condition of the patients, say two or three years afterward. He has a plan now under trial, but will not report it until sufficient time elapses to enable him to test its value. The tendency is to supplant cutting operations by others less dangerous, but which give equally successful results.

Dr. H. P. C. Wilson, of Baltimore, urged that the cases should be selected. When the uterus is bent upon itself and the posterior lip elongated, dilatation is often sufficient and accomplishes as much good as division. He has operated on nearly 100 cases with only one death, which occurred from peritonitis on the 14th day, after eating indigestible food. The danger of this operation is in not selecting proper cases, and is not so great as might be inferred from what has been said.

Dr. T. A. Emmet, of New York, had, in years past, performed the operation probably as often as any one except Dr. Sims. Observation has taught him that where the flexion is above the vaginal junction it is an expression of trouble elsewhere, the cause of which is not in the uterus itself. The uterus may be bound down by pelvic cellulitis, the result of inflammation. He never saw a case of this kind permanently relieved by an operation. Examination through the rectum will often in such cases reveal thickening of the broad ligament. The fault is not in the uterus, nor is it ever relieved by an operation. There is a certain class of cases in which the

neck of the uterus is developed out of proportion to the body. At the period of puberty the elongated uterus bends forward, becomes anteverted, and, from the pressure of the viscera, afterwards becomes anteflexed. In these cases dysmenorrhœa occurs at each period and continues to the end. In other cases dysmenorrhœa is due to constitutional causes, and after the first effect of the operation is over the dysmenorrhœa will return. If the condition is due to pelvic cellulitis, the operation will pass out of use and we will never hear of it again.

A case of Extra-Uterine Pregnancy, with discharge of Fœtal Bones through the Bladder was reported by Dr. JAMES P. WHITE, of Buffalo, who endorsed the opinion of Dr. Parry, that it is better not to operate on such cases but leave them to nature.

Dr. JOHN L. ATLEE, of Lancaster, reported, as an exception to this rule, a case operated upon by Dr. Walter F. Atlee, to be published in the October number of the *American Journal of the Medical Sciences*. He believed that when the health of the patient is failing it is proper to operate. If, in these cases, the placenta be allowed to remain the operation may become as safe and popular as ovariotomy.

Dr. D. HUMPHREYS STORER, of Boston, reported a case where, in the course of three months, all the bones of the fœtus were passed by the rectum. The patient has had two children since.

Dr. WHITE did not mean to say that no operative means should be instituted, or that the abdomen should not be opened, but that the rule should be not to interfere until circumstances demand the operation. By this time adhesions will have formed which will point out the line for our incision. The child is never saved.

Dr. T. G. THOMAS, of New York, reported four cases. He removed two through the vagina early in pregnancy. Unfortunately both died. Now he would leave them until nature calls for interference.

Dr. H. F. CAMPBELL, of Georgia, also favoured non-interference, and mentioned a case where a part of a mutilated fœtus being left in the uterus it ulcerated through its wall and was subsequently discharged through the abdominal parietes.

In the afternoon, Dr. J. T. JOHNSON, of Washington, reported a case of *Head and Foot Presentation in which a Fracture of the Spine occurred in Utero*. Delivery was accomplished by Simpson's forceps.

Dr. ENGELMANN, of St Louis, referred to a case where fracture of several bones took place some time before delivery. The child was born with a great number of bones broken, with others in the process of healing, united by callous. There is no history of injury to the mother, and the cause was unknown. The child was still-born.

Dr. NOEGGERATH had a case in which there was fracture of the humerus and of the thigh. The same child before her fifth year had thirty-two fractures. The bones were fragile, and slight causes produced fractures. At thirty-two years of age she was delivered by Cæsarean section, her pelvis being contracted to one-quarter of an inch. It was an extreme case of rachitic softening of the bones.

Dr. PENROSE, of Philadelphia, in a case of placenta prævia with head and foot presentation, had adopted a novel expedient to accomplish rapid delivery. By slipping a fillet over his hand he succeeded in placing it around the presenting foot. Dr. Fish, who was in attendance on the case, made steady traction on the fillet, downward and backward while the speaker pushed the head upward with one hand in the vagina aided by the other placed over the abdomen. Thus he was able to accomplish turning and delivery in a few minutes. The difficulty was increased by the placenta prævia, and he considered the method invaluable.

Dr. T. A. EMMET, of New York, read a paper entitled *The Necessity for Early Delivery as Demonstrated by the Analysis of One-hundred and Sixty-one cases of Vesico-vaginal Fistula*. This was accompanied by a carefully prepared tabular statement showing the number of hours in labour, the details of treatment under different modes of delivery—under the use of forceps, ergot and forceps, craniotomy, version and craniotomy, version alone, version and the forceps, and the results from other artificial means, compared with each other and with cases of natural delivery.

From the results given it would appear that vesico-vaginal fistula is generally due not to the use of instruments but to delay in the second stage of labour. A full bladder was declared to be a very common cause. A large proportion of the cases had been attended by midwives; the accident being comparatively rare among the better classes. In the table it was shown that in 70 cases it was nearly two weeks before the slough occurred, in 50 others urine escaped on the introduction of the forceps. The catheter should always be passed before putting on the forceps, and a male catheter may be found necessary. The loss of tissue is not in proportion to the violence of the pressure but its duration. The forceps should be applied as soon as the head remains stationary and does not recede after a pain. At this moment the danger to the woman begins, and delivery should be speedily accomplished. Of the 161 cases of operation 146 were cured, 9 improved, in 3 nothing was done; 1 died of other disease, and in 2 the result was not known.

Dr. A. H. Smith, of Philadelphia, said the number of cases of vesico-vaginal fistula have greatly diminished since the use of the forceps has become general. It is certainly strong testimony to the value of the forceps that was given by Dr. Emmet in the statement that he had never seen a case of vesico-vaginal fistula occur from the use of the forceps. In nearly 11,000 cases treated by the Philadelphia Lying-in Charity, where it was the standing rule to apply the forceps early, only one case of vesico-vaginal fistula occurred: in this case there was a rupture of the anterior wall of the uterus extending into the bladder. He agreed with Dr. Emmet that the danger was not in proportion to the duration of the labour nor to the amount of pressure, but to the length of time that the head was allowed to remain stationary, pressing against the pubic symphysis. When pressure becomes continuous, instrumental interference is required. As long as there are no evidences of acute metritis, or other local or constitutional dangers from exhaustion developing, as shown by increase of temperature, frequent pulse, etc., it is better not to interfere with the course of the labour, during the first stage, but in the second stage delay becomes dangerous. He inquired as to the rule of practice where the head is pressed against the symphysis and the metallic catheter cannot be introduced without force, and the head impacted too low to be pushed up, should delivery be accomplished without first evacuating the bladder, or should the head be promptly drawn down rapidly by the forceps from the position at which it presses upon the bladder and urethra, thus relieving the pressure and diminishing the danger of a slough?

Dr. Storer, of Boston, had attended several thousand cases of labour with only two cases of this accident. He strongly urged that the forceps should not be used unless impaction occur.

Dr. Fordyce Barker, of New York, said that no statistics have been brought forward for a number of years having such a bearing on practical obstetrics as these. Prepared by a person not prejudiced in favour of any treatment, and not having any theory to support, it throws valuable light upon a most important question. Although no new teachings are brought out by the paper, yet we find its results fully in accord with the most advanced obstetric teachings of the present day, and nothing has been presented that so well demonstrates the fact that these teachings are true, and that so well illustrates what they are doing for suffering woman. An over-distended bladder may cause delay in labor, not only from the mechanical obstruction, but also from the intense suffering caused by the pressure of the head upon the bladder at each uterine contraction, until by a reflex influence upon the uterus the extrusive force becomes insufficient. In cases of retarded labour, if the catheter is introduced the labour will often advance rapidly. Without heeding the statements of patient or nurse, he always used the catheter before applying the forceps. In the condition supposed by Dr. Smith, the forceps should be applied so as to take off the pressure from the symphysis pubis and evacuate the bladder before delivery. An over-distended bladder increases the

shock to the patient, increases the liability to post-partum cystitis, and often leads to pelvic cellulitis.

Even the first stage of labour, if protracted, is not without danger to the patient, by exhausting nerve-power and preventing the patient from sleeping, and by reducing the morale may prolong the second stage. Rest should be secured by large doses of opium and camphor. In some cases of delay he advocated rousing up the uterus by a large dose of quinia, which does not, however, exert the oxytocic power of ergot. The dangers of the forceps have been greatly over-estimated. In his experience he had never regretted using them, but recalled cases where he regretted not having used them. He dissented from the principle that the forceps should be applied as soon as the head ceases to recede. This depends on the position taken by the head in the pelvis and the condition of the soft parts, and may even happen in normal labour. He would rather say that they should be applied as soon as the head ceases to advance, the uterine contractions continuing in force.

Dr. J. L. ATLEE, when a student of medicine in Philadelphia, a little more than sixty years ago, learned from his uncle, Dr. A. L. Atlee, who was the first who publicly made known the danger of the use of ergot in primiparæ, that this is more frequently the cause of vesico-vaginal fistula than any other cause that can be imagined. In such cases he prefers to use the forceps. The older he becomes the more apt he is to use the forceps.

Dr. STORER thinks that all who have spoken are agreed on one thing, that when the head ceases to advance we should apply the forceps. We condemn their indiscriminate use without positive indications, as in inexperienced hands they are liable to produce accidents. He has not seen a case of lacerated perineum where the forceps had not been employed.

Dr. WHITE, of Buffalo, said that where laceration of the perineum is threatened the forceps should be applied to control the head. We get our fear of the forceps from English teachings; but a great revolution is taking place in England on this point. In looking over the statistics we find one of the older authors applied the forceps to one in six hundred cases. But in a paper recently presented to the London Obstetrical Society, which was received without dissent, the proportion of cases requiring the forceps was stated to be one in ten.

Dr. EMMET said that in cases of labour delayed by distension of the bladder the child is generally still-born. In the case of impaction, where the catheter cannot be introduced, he would recommend the use of the aspirator to draw off the urine, as is frequently done in the male. He would insist that the woman must be delivered as soon as the head ceases to recede. He requested Dr. Barker to define under what circumstances the head ceases to recede, except from loss of elasticity of tissues.

Dr. BARKER said that the experience of every one shows that this depends often upon the position of the head—when the head is rotated anteriorly at an early period of labour; and it never takes place in cases of occipito-posterior positions. The head ceasing to advance furnishes the indication for applying the forceps.

Dr. GOODELL agreed with Dr. Smith and Dr. Barker that the catheter should be introduced before delivery by the forceps. He would not recommend a hasty application of forceps by young men. While Drs. Smith and White may save the perineum, an inexperienced practitioner would tear it. Lacerations of the neck of the uterus, in his experience, were generally caused by the use of the forceps.

Second Day.—Dr. H. P. C. WILSON, of Baltimore, reported a case illustrating the value of the *Hand as a Curette in Post-partum Hemorrhage.* In a case of obstinately recurring hemorrhage ergot had been ineffectually given to the extent of one ounce and a half, by the mouth, hypodermically, and by the rectum; ice and manipulation also had failed, when scraping the placental surface permanently checked the bleeding, and a good recovery followed.

Dr. R. A. F. PENROSE, of Philadelphia, read a paper on the *Treatment of Post-*

partum Hemorrhage, in which he recommended a plan of treatment which had never failed in his hands. The idiosyncrasy of a weak uterus is the great predisposing cause to uterine inertia, which usually accompanies post-partum hemorrhage. Plethora, in some cases, undoubtedly favours the accident. The existing causes are well known, and need not be dwelt upon. The curative treatment, since the hemorrhage depends upon different conditions, must necessarily vary with the nature of the case. Ergot, friction and pressure, irritation of vagina and interior of uterus, etc., the effects of impression made upon distant organs, such as the stomach; and the use of stimulants, opium, or oil of turpentine are often necessary. When, in spite of our ordinary remedies, the rectum refuses to contract, in certain cases the application of a solution of the persalts of iron or of tincture of iodine may be justifiable. The agent which he has found to be *the* remedy for post-partum hemorrhage is common vinegar. He has had only one case of death follow its use, but this could not be attributed in any degree to the injection. This treatment is not original, but it is convenient, safe, and efficient, and at the same time astringent and antiseptic. It is used without apparatus, by dipping muslin or linen rags in the vinegar and carrying them into the uterine cavity by the hand. Several applications may be required. In desperate cases, where this remedy fails, which is scarcely deemed possible, resort should be had to the solution of persalts of iron, on the principle that dangerous conditions require desperate remedies.

The discussion was opened by Prof. WHITE, of Buffalo, who agreed with the author that uterine torpor was the general condition accompanying the bleeding, and that in the great majority of cases it could be prevented by proper management of the later stages of labour. He believed that while Dr. Wilson's expedient of introducing the hand may prove useful, it acted chiefly as a mechanical irritant or stimulant to the uterus. The only way to close the uterine sinuses is to secure firm contraction of the uterus. He uses acetic acid as a styptic, mopping the uterus with it, by means of absorbent cotton wound on a probe, to arrest hemorrhage after operations.

Dr. GAILLARD THOMAS believed that post-partum hemorrhage was always due to one of three causes: First, to want of power in the uterus itself, uterine atony or inertia; Second, the presence of some mechanical cause, such as uterine fibroid, retained clot or part of placenta, preventing the contraction of a willing uterus; Third, hemorrhage from solution of continuity or lacerations of tissue, or the rupture of a hæmatocele. He believed that in the great majority of cases uterine inertia is due to some neglect on the part of the attendant. A clot is allowed to collect after delivery and cause this condition. The physician should not leave his patient until he has secured the firm contraction of an empty uterus, he should always remain with his patient for one hour, and should stay twelve hours if necessary. Until this is done he should feel that the woman is in great danger. Throwing aside the binder as one of the superstitions of a past age, he should aim to accomplish complete uterine contraction. To do this, the safe practitioner will not rely upon any one remedy. In many cases any irritant applied to the inside of the uterus would be sufficient; dilute alcohol or hot water answers as well as sulphate of iron, the great danger of which will prevent it from ever coming into general use.

Dr. J. L. ATLEE recommended the introduction of the hand as a stimulant to the interior of the uterus, and it should be kept there until the uterus firmly contracts. Post-partum hemorrhage is often favoured by muscular weakness and want of exercise during gestation. In such cases ergot has proved very efficient as illustrated by the history of two patients.

Dr. ALBERT H. SMITH divides the cases into two classes, first, those arising from distension of the uterus; and secondly, those caused by laceration. The law of organization of the contractile tissue of the uterus makes it contract if it is empty. He was therefore pleased with Dr. Thomas's remarks that if we empty the uterus it will contract. Any manipulations or

applications made will not be successful until the uterus is put into a condition to contract. A clot acts like a splint, keeping open the uterine sinuses and allowing them to bleed. A piece of retained placenta will also produce hemorrhage.

For the past two years he has been using injections of hot water of about 110° F., injecting the water at the same time that he turned out the clots. By this means there were less after-pains and less lochial discharge, and it was always followed by good results. The persalts of iron he considered a dangerous remedy.

Dr. ENGELMANN, of St. Louis, had not seen any bad results from mopping the surface of the uterus with solution of iron.

Dr. TRASK, of Astoria, L. I., said that in such cases the iron acted as a stimulant, and not by virtue of its specific property as a styptic. The uterus generally contracts immediately on its introduction, but other agents are equally efficient and less dangerous. The injection of dilute tincture of iodine originated by Dr. Pirie, of Cuba, had proved in his hands always satisfactory.

Dr. CHADWICK, of Boston, had used the iron in four cases, and thought that it induced septicæmia. Where this had occurred he found that permanganate of potassa injected into the uterus had been followed by recovery in three of the patients. The fourth, in whom the permanganate was not used, died of septic poisoning. In cases of inertia of the uterus he had found subcutaneous injections of ether to be promptly efficient.

Dr. BARKER said that other causes existed for post-partum hemorrhage than had been referred to, and mentioned as one of these the hemorrhagic diathesis, which requires preventive measures during gestation. He referred to a case of this kind in which full doses of ergot were given, and constant pressure of the hand upon the abdomen was required for a period of six hours and a half. He would refer to two other causes of uterine hemorrhage than had been mentioned. First a class of cases where the fœtus is expelled so rapidly that the uterine fibres have not time to contract; and, secondly, the opposite condition where the labour is so prolonged that the uterus becomes exhausted. No procedure is so valuable as that described by Dr. Bozeman of placing one hand in the uterus and the other upon the abdomen and attempting to excite uterine contraction. And the hand should be allowed to remain until expelled by uterine contraction, as mentioned by Dr. Atlee. Some caution should be used, however, in introducing the hand. The cases are very rare where it will be necessary to practise this, except where there is partial adhesion of the placenta. He has seen injury resulting from the introduction of the hand into the uterus, and it should not be resorted to until other remedies have failed. He mentioned a case where the labour was neither severe nor protracted, but was followed by some hemorrhage. The physician introduced his hand into the uterus, and shock and continued loss of blood followed. He was called to see the case, and upon vaginal examination, detected a laceration of the cervical portion of the neck running up to the vaginal junction. Symptoms of septic poisoning set in on the second day, and she died in twenty-four hours.

In the *Annual Address by the President*, Dr. WILLIAM GOODELL, of Philadelphia, after paying a graceful tribute to the memories of Drs. Edmund R. Peaslee and W. L. Atlee, discussed the *Relation of Neurasthenia to the Diseases of the Womb*. In this able contribution great stress was laid upon the fact that local disorders of the uterus and ovaries are freqdently merely the expression of constitutional states whose existence must not be overlooked.

Dr. WILLIAM H. BYFORD, of Chicago, read a paper on *Dermoid Tumours of the Ovaries*, and gave the following as the theory of their development: "In the early period of ovulation or embryonic development, by some accident or modification of formation, indentation of the blastoderm is produced or somehow exists. In the wonderful developmental energy of that period, the minute depression is inclosed by the approximation of its blastodermic margin, and becomes an isolated cavity, and the growth and perfection of the em-

bryo are accomplished, notwithstanding this early accident to the integrity of its envelope. The depression thus formed involves perhaps both layers of the blastodermic membrane, but the external layer becomes the lining membrane of the cavity, and is speedily cut off from the rest of the blastodermic surface, and invaginated with all its essential structures and processes of organization; all its organs, therefore, must be retained in the cavity. The contents of that cavity correspond in miniature with what the formation might have been if the displacement had not occurred. In the further development of the embryo the portion of the blastoderm covering this adventitious cavity develops its tissues and organs in the ordinary way, and thus incloses it in the body by the structures usually found to cover it. The internal layer of the blastoderm is doubtless also displaced, but it is not isolated, and, secondly, its products are never found inside of the tumour. Therefore, in instances where the dermoid patch occupies any of the mucous cavities the neoplasm will always be found external to the mucous membrane. This theory serves to explain why these hairy tumours are found in the fœtus, or the virgin, matron, and male, and with equal plausibility why they may exist in any part of the body."

Dr. Noeggerath described the mode of combination of the dermoid with the colloid or myxomatous tumour. Three varieties are observed. They are formed first by juxtaposition, one side of the tumour containing colloid elements, and the other dermoid. In another series of cases the characters are mixed throughout the cyst, making it partly caseous and partly adenomatous. There is a third class of tumours where a large serous cyst forms in the dermoid tumour itself by retained secretion of the sudorific glands.

By the term inclusion, which Dr. Byford has used, we mean at the present day not any inclusion of a part of a second fœtus. We know that the genital organs are developed from the axis cylinder; and, secondly, from the primordial vertebra. In the formation of the Wolffian body in the process of the development of its parts, we find at some point adhesion may occur between the epiblast and the mesoderm, thus including some of the cells of the epiderm, and accounting for their presence in the ovary according to Waldeyer's theory. At the time of puberty this is apt to take on rapid development from the special *nidus formativus* existing in the ovary itself. Thus epithelial cells are found among the stroma, explaining the presence of these tumours in the virgin. The same theory explains their presence in other parts of the body.

Dr. W. L. Richardson, of Boston, presented *A Contribution to the Study of the Treatment of the Acute Parenchymatous Nephritis of Pregnancy*, in which he stated that albuminuria occurs in 42 per cent. of pregnant women, and is not so rare nor so dangerous a combination as supposed. In 26 cases occurring in his own practice, convulsions appeared in 14. The decrease in the quantity of urine in such cases is always a signal of danger. He recommends the systematic examination of the urine of pregnant women even when no trouble is suspected; and, secondly, when we find albuminuria, the urine must be measured daily, and whenever we find it falling below the average, must endeavour, by general means, to increase it. If this is unsuccessful, we should induce labour, which becomes more imperative when the pregnancy has reached that period when the fœtus is viable.

Dr. Gaillard Thomas fully endorsed the paper. In an obstetrical experience, extending over a period of twenty-seven years, he could recall only two cases where the puerperal convulsions were not attended by albuminuria; and in one of these a small amount of albumen was subsequently detected, the renal secretion not having been examined previously. He did not mean to say that the albuminuria caused the convulsion, but that it accompanied it. In such cases, where stertorous respiration at night occurs—a most important symptom — where amaurosis appears, and the secretion of urine becomes deficient, the fluid becomes three-fourths solid by heat and nitric acid, nothing will relieve the symptoms but the induction of premature labour; but other means must be previously tried, as

pointed out recently by Dr. Barker, and referred to by the author of the paper. Pilocarpin promises to be a valuable remedy. According to his experience in the great majority of these cases, medicines will almost invariably fail, and labour must be induced. He could not recall a single case in which he had induced labour for these convulsions where he had regretted it.

Dr. JOHN L. ATLEE said that he had followed the teachings of Dr. Dewees, and used the lancet, and he had yet to lose his first case.

Dr. FORDYCE BARKER said that his experience would not warrant him in going to the extent Dr. Thomas had in placing such exclusive reliance upon the condition of albuminuria. He had reported a number of cases where this condition was not found, although it is almost always an accompaniment. Nor did his experience agree with that of Dr. Tyler Smith as regards the general results of treatment. He believed very strongly in medical treatment, but he also believed that premature labour should be brought on where there are symptoms indicating danger to the mother or the child. One of the most striking symptoms is the presence of albuminuria; if it persists, and dangerous symptoms appear, labour should be induced. He agreed with Dr. Atlee as to the value of bloodletting in obstetric practice as prophylactic against convulsions, and as a protective against the consequences of blood-poisoning by defective renal secretion. It removes part of the poisonous material, and supplements the action of the kidneys. Lives have been saved by it. The great remedial result from bloodletting is in saving the system from the effects of the convulsions.

Dr. GEORGE H. LYMAN, of Boston, said that in addition to the cause mentioned, which was a frequent one, the eclampsia may be due to hysteria and to epileptic convulsions following delivery.

Third Day.—The following report was received from the Nominating Committee, and adopted: Officers for 1879: President, T. Gaillard Thomas, M.D., of New York; Vice-Presidents, Drs. D. H. Storer, of Boston, H. P. C. Wilson, of Baltimore. Council, Drs. T. A. Emmet, of New York, Albert H. Smith, of Philadelphia, John Byrne, of Brooklyn, George J. Engelmann, of St. Louis. Secretary, J. R. Chadwick, M.D, of Boston. Treasurer, P. F. Mundé, M.D., of New York. Honorary Fellows, Drs. J. S. Billings, U. S. A., and J. Matthews Duncan, of London. Fellow, Nathan Bozeman, M.D., of New York.

Next place of meeting, Baltimore; time, third Wednesday in September, 1879.

Alternating Anterior and Posterior Version of the Uterus, was illustrated by Dr. S. C. BUSEY, of Washington, D. C., by a case in which this condition was apparently brought about by an elongated and cartilaginous cervix. The uterus being bound down by tension of the lower part of the left broad ligament was forced into these changing relations, by alternating conditions of rectal and vesical distension or collapse.

The next paper was on *Gastro-Elytrotomy*, by Dr. H. J. GARRIGUES, of Brooklyn. The history of the operation was reviewed, and its results contrasted with those of Cæsarean section. Baudelocque's is the only case in which the operation was performed prior to that of Dr. Thomas. Passing over the discussion of the dangers and the details of the operations of Cæsarean section, and its comparative mortality, he observed that of all the cases of Cæsarean section performed in New York City for the last two hundred and fifty years, only one was successful. Indeed authors claim only from 54 to 62 per cent. of recoveries. Dr. Thomas originated the operation anew, and proved its practicability by dissections, before he performed it in a living woman. Dr. Skene, of Brooklyn, has also performed it with success. The operation has been performed five times in all; four of the children were saved, and three of the mothers are still living.

The chief danger in the operation appears to be in the hemorrhage from the vaginal wall. To obviate this Dr. Thomas makes a small opening sufficient to introduce two fingers, and then tears it up and down to the desired extent. The author recommended the primary opening

to be made by the galvano-cautery, subsequently enlarged by the fingers, in a transverse direction, or parallel with the brim of the pelvis.

In reviewing the steps gone through in originating the operation, Dr. GAILLARD THOMAS said that in his case it would certainly seem that "when ignorance is bliss 'tis folly to be wise," for if he had known of the unfortunate cases reported by Ritgen and Baudelocque, he never would have had the courage to perform the operation upon the living subject, and indeed had his first operation been unfortunate, he should have felt like a distinguished surgeon at his first ovariotomy, many years ago, who declared that if it had proved unsuccessful he never would have repeated it.

A woman, in the ninth month of pregnancy, having died with convulsions, he had the opportunity of demonstrating upon the cadaver the value of the operation, which he then believed to be new. Dr. Noeggerath told him that he had read of it before, and subsequently referred him to the cases of Baudelocque and Ritgen; but not before he had successfully repeated the operation upon a living woman. If in Baudelocque's place, he would have been ashamed to publish the two cases in which he opened the iliac artery, as they are not creditable to his skill. He once saw an operation for ovariotomy where the operator cut directly into the bladder without recognizing it, and coolly dissected it off from the tumour to which it was adherent; the woman died upon the operating table. A skilful ovariotomist would never have made this mistake. So in performing this operation he never even saw the external iliac artery, and would have had to go out of his way to expose it. But even if it should be wounded there is nothing to prevent a ligature being thrown around it or even from proceeding to tie the common iliac if necessary. There is a large opening to work in, and hemorrhage is overcome as easily as in other surgical procedures. To avoid hemorrhage after the operation, the vagina can be packed with a tampon of carbolized cotton, another plug being packed into the iliac fossa, a bandage carried tightly around the waist will now press the two tampons together, and make firm compression, should any tendency to bleeding be observed. No bleeding can persist. The tampons should remain not longer than twenty-four hours. He would have used this in the last case had hemorrhage followed the operation.

The question for operators to decide is, which is the safer for the mother and the child, this operation or the Cæsarean section? It is universally acknowledged that Cæsarean section is the most dangerous operation of surgery. Gastro-elytrotomy has been performed only five times on living women, one of whom was moribund at the time of the operation, which was performed to save the child under the following circumstances: The family were exceedingly anxious that the child should be born alive, so that it might be baptized. The question was, in what way can you deliver this fœtus from this practically dead woman with more safety, by version or Cæsarean section? He compromised, and performed gastro-elytrotomy, and saved the child. He preserved the only living one of his two patients. He then referred to a case of Dr. Skene. In this instance the fœtus was dead. In this case the mother's life was saved. His last operation was under particularly unfavourable circumstances, and it should be remembered that this operation has not been performed upon selected and favourable cases. It is claimed that Cæsarean section is not resorted to until the cases are given up, and other procedures are hopeless, but it must not be concluded, *per contra*, that gastro-elytrotomy is performed upon exceptionally favourable cases. This operation offers a choice where gastro-hysterotomy is otherwise indicated. In the last operation, the patient had been for some time, sixteen or eighteen hours, in labour when natural delivery was found impossible. She was then put in a carriage, and driven from the town of Harlem to New York, and was placed in a lying-in hospital, which had all the faults of its class, and had been exposed to septic influences for years. The problem was, should we perform

Cæsarean section or craniotomy? At the consultation he recommended gastro-elytrotomy, and he performed the operation. The child was safely delivered. The mother was perfectly well at the end of three weeks. Recovery was delayed by severe chills, which were probably not septicæmic, as they were controlled by quinia, and she came from a malarial neighbourhood.

No especial difficulty attended the operation. After making the incision in the median line, as in Cæsarean section, avoiding the peritoneal cavity, the peritoneum was carefully peeled off on the right-hand side, and the wall of the vagina dissected from its attachment to the extent of two and a half to three inches. A small opening was then made, sufficient to introduce two fingers, and the vagina torn both upward and downward. In the delivery of the child this opening becomes stellate, and the right wall of the vagina annihilated.

Dr. Thomas asked, Why is it that in the last two hundred and fifty years, in all the operations by Cæsarean section that have been performed in the city of New York, there has been but a single successful case, while in the same city in the last eight years, out of five cases of gastro-elytrotomy there were three recoveries? This cannot be accidental. In one of the cases reported by Dr. Skene, the condition was so desperate, and the results of the operation so marked that it reads like a romance, and he could scarcely believe it had it not been given on such good authority.

The danger of wounding the bladder, which has been referred to, is not of great importance. We know that in the modern operation of making an artificial opening into the bladder for the relief of cystitis, the great difficulty is in keeping the wound from healing, and we have to resort to the actual cautery to keep it open. If the bladder should be accidentally cut in the operation, which need not happen in the hands of a skilful surgeon, it will heal of itself; it requires absolutely no treatment. In regard to cellulitis, he thought that with antiseptic precautions it may be avoided. It is not necessarily the result of the operation.

Dr. Byford thought the chief advantages of the operation are that it gives a free outlet to the fluids, the peritoneal cavity is not opened, the body of the uterus is not wounded, and finally the operation does not interfere with the subsequent performance of Cæsarean section. It could be performed, he thought, as successfully as ovariotomy, were it not for the fact that it is done during pregnancy, when the pelvic viscera are in a state of exaggerated nervous and vascular supply. From what he had heard he would favour the operation. Peeling off the peritoneum is not more dangerous than when undertaken for tying the common iliac artery, when it is not considered of special importance.

Dr. Bozeman, of New York, said that a surgical objection to the operation would consist in the fact that as the ureters course along the side of the vagina they must be ruptured in this operation and uretero-vaginal fistula result. This he thought had occurred in those cases where it was supposed the bladder had been opened. In the successful cases, the continuity of the ureter must have been restored in the process of healing. The danger of this complication will be inferred from the fact that only one case is known to surgery where rupture of the ureter has been followed by recovery.

Dr. Garrigues advocated a horizontal or oblique rupture of the vagina instead of the longitudinal one proposed by Dr. Thomas, since the greatest vascularity of the vagina is near its two extremities.

Dr. Thomas, in reply to Dr. Bozeman, said that in his first operation he was afraid of wounding the ureter and searched for it, but did not carry his dissection far enough to encounter it. He did not think that it was necessary to expose it. The fact that there is on record but one case of recovery after rupture of the ureter he thought was sufficient proof that this accident had not occurred in his successful cases.

In a paper on *Pendulum Leverage of the Forceps* Dr. Albert H. Smith, of Philada.,

particularly discussed the advantages of direct traction over the pendulum movement in delivering the head where there was delay in the second stage of labour, and he presented the following conclusions:—

1. That pendulum movements are in direct violation of the teachings of nature.

2. That they are absolutely useless as far as aiding traction is concerned.

3. That any virtue they have is by stimulating uterine action which then operates entirely independent of them.

4. That so far from diminishing friction, they increase the mutual pressure of the head and pelvic walls, thus increasing friction.

5. That they tend to do injury to the pelvic tissues no matter at what point of the pelvis they are practised.

6. That so far from being specially useful when the head is "tightly gripped," to use Dr. Galabin's expression, and the extraction difficult; the greater the difficulty of the case, the greater necessarily is the injury to the tissues.

7. That so far from economizing force they waste it.

Dr. Jas. P. White said that the forceps in shortening the second stage of labour, often prevent the injurious effects of delay upon the maternal tissues, and enables us to save the lives of children that would otherwise perish. Its powers are said to be three—traction, compression, and the lever movement. In regard to the traction, little need be said beyond the fact that it should be in the line of descent, and applied during the pains. The child's skull is compressible to a considerable degree, under the pressure of the forceps; its bi-parietal diameter decreased and its long occipito-mental diameter is increased. This compression, however, should not be applied continuously as, by interfering with the circulation of blood in the brain, it would slaughter the child. Between each pain the head recedes and the circulation goes on. This power of compressing the head is of considerable importance in accomplishing delivery. In regard to the lever movement, he believed that those who advocated and recommended it most strongly did not use it nearly so much as their writings would lead us to infer. Some authors would make us believe that we must depend mainly upon lateral movement and rotation, which is absurd. But where there is delay in the early part of the descent of the head, a gentle movement of the handles towards the left iliac region, if the head is in the first occipito-anterior position, and then posteriorly and to the right, will often give it a start that is of great assistance; but it should never be a prominent aid to delivery. While traction is our chief reliance, sometimes gentle motion may be made with benefit. In regard to the lateral movement, no hard rules can be laid down, while the operator must be perfectly familiar with the anatomy of the pelvis and its relations to the descending head, he must be guided by good judgment.

Dr. Fordyce Barker was glad to discuss a paper so full of suggestive points as this valuable contribution, but he could not do justice to all the points in the short time allotted. He would first review the ground to see in what points he could agree with the author, and then take up those wherein they differed. The forceps are first a valuable instrument of traction, and secondly of compression. Now in what direction is the traction to be made? In that of the canal where the head happens to be. So far we are agreed. We also agree that it is an instrument of great value where any difficulty exists interfering with the progress of the mechanism of labour. In those cases where the occiput fails to rotate under the symphysis pubis, he supposed Dr. Smith would allow a pendulum motion to encourage the head to complete the rotation. Now, wherein do we differ? The author believes that the traction should always be made in a direct line, wherever the head should happen to be, at any point in its course from the entrance of the cavity to the outlet. He believes we should never carry one extremity of the bi-parietal diameter faster than the other. In the diagram a fallacy is noticed which runs through the author's argument, that the centre of the bi-parietal diameter is a

fixed point, and that if one side of the head advances the other must proportionately recede. This centre is not a fixed point. He would advocate moving both sides of the head, but one more rapidly than the other. This is a question of physical law and not a process of reasoning. Placing his knife transversely between his fingers, he assumed that the knife represented the transverse diameter of the head and his finger and thumb the soft parts contained in the pelvic cavity. Now by what process would the tissues receive the least friction by advancing both ends equally or by moving one side a little more rapidly than the other? The great objection that Dr. Smith would urge is the danger to the soft parts of the pelvis by the lateral motion; but it is seen by this illustration that the injury to the soft parts is less. If we represent the amount of friction on the side of greatest motion by the number 10, the amount on the opposite side moving half as fast would be 5 and the danger would be reduced 25 per cent. There is an additional advantage in the fact that alternately each part would have a period of rest. He did not wish to be understood as advocating extreme motion, nor should he ever think when one side is advancing of allowing the other to recede.

Dr. D. H. Storer desired to mention a case showing the evil effects of compression of the skull by the forceps. A gentleman had deep furrows over the parietal bones, which were produced at his birth by the forceps. The patient was eccentric, and almost idiotic, and died at an early age. He wished to impress the fact that too great pressure upon the head may destroy the man.

Dr. Penrose advocated the Philadelphia treatment as laid down by the late Hugh L. Hodge, that ordinarily only sufficient pressure should be applied to make the head and the forceps one body, but, under certain circumstances, they may be used as compressors. As levers, they should only be used to assist their action as tractors; or in a general way only to dislodge the head when it ceases to recede. By this method he has delivered children that could not have been delivered alive by any other means.

Dr. Gaillard Thomas said that, in addition to the powers of the forceps that had been enumerated, he was in the habit of classing them as rotators. And this, he thought, was the explanation of the misunderstanding between the author and Dr. Barker. He confined his remarks to considering the lever movement by itself. Is it best to deliver a head directly by traction or by resorting to the pendulum movement? Early in the course of labour this is not necessary, but where the second stage is prolonged, the head remaining in the pelvis for four or five hours, interfering with the return of venous blood from the parts below, the tissues forming an œdematous ring beneath the head, then a slight lateral motion, forcing out the serum from the swollen tissues, is of great value, and is perfectly legitimate. The latter movement should be slight and not of an exaggerated swaying character.

Dr. Goodell considered the subject as a many-sided one, and he was in accord with the teachings of Dr. Smith in gross, but differed with him in certain particulars. In regard to the lever movement we must ask first, Is it an injury to the mother's tissue, and secondly, is it a mechanical advantage to delivery?

Compression moulds the head to the cavity, and accommodates it to the pelvic inequalities. It can be delivered by lateral motion alone without the aid of traction from the forceps. The head is never moulded exactly to the pelvis, and the forceps are never applied exactly over the parietal bones. Moreover, no pelvis can be found which is perfectly symmetrical. In regard to the safety of the mother, it must be confessed that injury may be accomplished by lateral motion, and it is a very rare thing for him to use it. The danger increases as the head descends into the lower portion of the pelvic canal. As an aid to delivery, if the head be moved the friction is less than by steady traction, and it causes the head to accommodate itself to the canal by a change of shape.

In his view of the forceps as a mechanical aid, Dr. Smith was sorry to stand alone, but was not convinced of his error. If the object is to compress the

head by lateral motion, why not use the forceps directly for that purpose, and save the mother's tissues? The forceps are to be used with just enough compression to take off the friction of the head from the soft parts. He thought that Dr. Barker and Dr. Thomas had both overlooked the fact that the fœtal head is not shaped like a knife, but is an ovoid body. He, therefore, could not admit the force of the simile. In regard to Dr. Thomas's case, where the puckered-up tissues are in advance of the head, shall we not produce less danger to these tissues if we make traction directly downward in the line of least resistance? And if by a swaying movement we condense the tissues already congested and bruised, in the end we dilate just as much. As a general rule, the forceps should not be used as rotators; but neither should they resist rotation. We should allow the forceps to rotate with the head in obedience to the mechanical law of the pelvis, just as the German school believe in allowing the head to rotate in the grasp of the forceps; but he could see no analogy between allowing the forceps to follow the head, and the backward and forward and swaying movements that have been recommended. Every one who has spoken terms this a dangerous method, but all seem to want a little of it. They do not recommend this procedure in simple cases but only in difficult ones. But the more difficult the case, the more tightly the head is held in the pelvis; the more that simple traction seems likely to fail, the more danger there is in the lever movement. From his own experience he knew that he could deliver the child with vastly less force with slight compression with direct traction than he could with leverage combined with traction.

In searching for illustrations, we must remember that the head is fixed by resistance from surrounding parts, and not by any fixed point. This must be overcome by taking off the pressure of the head from the tissues by slight compression. In traction there should be no deviation from the line of the pelvic canal, as was recently taught by Tarnier. If two-thirds of the force be lost in pressing the head against the side of the pelvis, as recommended by Bedford, only one-third of the force is available for the delivery.

Dr. Henry F. Campbell, of Augusta, Georgia, read a paper on *Rectal Alimentation in the Nausea and Inanition of Pregnancy*, illustrated by a case where for fifty-two days no other mode of feeding was employed. One-half pint of beef essence was injected twice daily. The enemata were retained, and apparently passed through the ileo-cœcal valve into the small intestine. The nutrition of the patient was sustained; she aborted, was delivered of a still-born child, and made an excellent recovery. Ulceration of the cervix uteri was discovered early in the history of the case, which resisted treatment. In order to determine whether enemata could pass into the small intestine, Dr. Campbell made an experiment upon a kid, to which he gave nutritious enemata stained with some colouring matter; the animal was killed on the eighteenth day, and the coloured material was found throughout the small intestine as far as the fourth stomach. For this retro-peristalsis Dr. Campbell proposed the name of Intestinal Inhaustion.

Dr. Jas. P. White offered the notes of a case of *Punctured Wound of the Rectum*, which were not read, owing to the arrival of the hour of adjournment.

On motion of Dr. White a resolution was unanimously adopted, thanking Dr. Chadwick for his valuable, arduous, and otherwise unrequited labor in performing the duties of Secretary of the Society, and superintending the publication of its Transactions.

On motion of Dr. Barker, a vote of thanks was tendered Dr. Goodell for the ability and faithfulness with which he had performed the duties of presiding officer of the meeting.

Dr. Goodell said that in bringing the session to a close he congratulated the Fellows upon the high position which the Society had taken, the eagerness with which its membership is sought, and the active demand for copies of its Transactions.

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The different nervous diseases are taken up systematically and fully treated The volume throughout is written in clear and practical language, and contains in brief the salient points of clinical history, diagnosis, pathology, and treatment of nervous diseases recognized at the present day. The work has been prepared with a view of meeting the wants of the student and general practitioner. Whenever necessary, handsome illustrations are added to explain the text. It is a volume which will supply a need long felt by the profession, and to Dr. Hamilton the profession is indebted for this clear and able classification of nervous diseases and a publication of uncommon merit.—*Md. Medical Journal*, Aug. 1878.

The treatment is up to the requirements of the most advanced therapeutical and pathological knowledge. The work is free from dogmatism, and as a whole may be accepted as containing about the best information on the subjects within its scope, compressible within so limited space. It is lucid and direct in style, and the author certainly has succeeded in his purpose, as announced in the preface, of producing a "concise and practical book."—*Cincinnati Lancet and Clinic*, July 20, 1878.

In the modest preface to his work, Dr. Hamilton expresses the wish that he may have made the diagnosis and treatment of nervous diseases more simple. We believe he has succeeded in this in an eminent degree. His book is a safe guide for the general practitioner, and an excellent text-book for the student, inferior to none that we know of, and vastly superior to some that we forbear to name.—*Ohio Med. Recorder*, Aug. 1878.

As stated in the preface, the author's object has been to write a concise and practical book, for which there is certainly a place, and we think he has succeeded admirably in fulfilling his object. The usual plan is adopted in the classification of the different diseases, the book being not greatly unlike Hammond's in this respect, although it is very noticeable throughout that the author's opinions vary widely from those of Dr. Hammond.—*Am. Supp. Obstet. Journ. Gt. Britain and Ireland*, July, 1878.

A wide acquaintance with the recent literature of nervous disease is manifested throughout, and an attempt—and a successful one—is made, to do away with much of the obscurity and confusion arising from physiological themes, which cloud several of the more popular recent works on the same subject.—*Med. and Surg. Reporter*, July 6, 1878.

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